PART I

MEDICAL PLAN

The Medical Plan provides benefits for medical coverage. Enrollment in the medical programs is optional.

WHO IS ELIGIBLE FOR THE MEDICAL PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the group Medical Plan on the first day of active employment.

Eligible Dependents

The following members of your family are also eligible for Medical Plan coverage:

- Your spouse.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must share a committed and exclusive arrangement that meets all of the following criteria:
  - — Both the enrollee and the domestic partner are eighteen years of age or older and unmarried, and
  - — Are of the same sex as each other, and
  - — Are not related by blood in any manner that would prohibit legal marriage, and
  - — Have assumed mutual obligations for the welfare and support of each other (proof of financial interdependence is required), and
  - — Have been sharing a common residence and living together as a couple in the same household for at least twelve months, and
  - — Are each other's sole domestic partner, and neither person has had a different partner less than twelve months before completion of BSA's Affidavit of Domestic Partnership.

  Children of your eligible domestic partner must meet the criteria for unmarried children indicated below.

  This section does not apply to active employees who are members of the SCSPA union.

- Your unmarried children up to 19 years of age, including adopted children and stepchildren who are dependent upon you for support. Stepchildren must reside with you to be eligible for coverage.

  — Under the Preferred Provider Organization (PPO) and Open Access Plus (OAP) programs, administered by CIGNA, and the Vytra Health Maintenance Organization (HMO) and PPO programs an unmarried child is considered to be eligible for dependent coverage up to his or her 19th birthday.

  — Under the Aetna and HIP HMOs an unmarried child is considered to be eligible for dependent coverage through the end of the month in which his or her 19th birthday occurs.

- Your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond age 19 if, within 31 days after they have reached age 19, you submit proof of the child's incapacity. Coverage may be continued for dependents who are over age 19 and who become mentally or physically incapable of earning their own living while covered as an eligible dependent, by submitting proof of the child's incapacity within 31 days after they become incapacitated.

- Your unmarried children age 19 and over who meet the following criteria:

  — The dependent child must be the taxpayer's child, including adopted child or stepchild.
  — The dependent child must have the same principal residence as the taxpayer for more than one-half of the tax year. Children who are away at school will not be excluded by this criterion as long as when they're not at school, they are living with you. Children of parents who are divorced will not be excluded as long as they are living with one of the parents for at least one-half of the tax year. Please note that stepchildren must reside with you to be eligible.
  — The dependent child must not provide more than one-half of his or her own support.
  — For a dependent child who is age 19 or over to be eligible for coverage, he or she must attend an accredited college or university on a full-time basis and also meet the criteria indicated above.

  Coverage for such unmarried children will end on the earlier of (a) the end of the year of attainment of age 23 or (b) when they no longer meet the criteria indicated above. If they are no longer eligible for coverage because they are no longer attending an accredited college or university on a full-time basis, coverage will end as follows:

— For the PPO and OAP programs, administered by CIGNA, the Aetna, and the Vytra programs, dependent coverage ends as of the end of month in which he or she is no longer a full-time student.
— For the HIP program, dependent coverage ends as of the date he or she is no longer a full-time student.

Dependents of Deceased Participants

If you are participating in the Medical Plan and die while in active service, while receiving Long Term Disability (LTD) Plan benefits, or while on retiree medical coverage, your covered dependents may continue in the plan, for one year following the date of your death, by paying the required employee premiums.

After the first year:

- If you had less than 3 years of Continuous Service, your covered dependents may continue in the plan under the COBRA provisions by paying the COBRA cost of the plan.
- If you were not in the calendar year of your 58th birthday or later and do not meet the eligibility requirements for retiree medical coverage (see below) and you had at least 3 but less than 15 years of Continuous Service, your covered dependents may continue in the plan by paying the COBRA cost of the plan.
- If you were not in the calendar year of your 58th birthday or later and you had at least 15 or more years of Continuous Service, your covered dependents may continue in the plan by paying the required retiree premiums.
- If you were in the calendar year of your 58th birthday or later and had at least 3 years of Continuous Service, your covered dependents may continue in the plan by paying the required retiree premiums.
- If you meet the eligibility requirements for the retiree medical coverage (see below), your covered dependents may continue in the plan by paying the required retiree premiums.

These provisions will not apply to covered dependents if eligible for coverage under another group medical insurance plan. Coverage will terminate when they no longer qualify as eligible dependents. Coverage will also terminate for covered dependents on the date the surviving spouse remarries.

Retirees

All employees who are participating in the Medical Plan and who terminate employment after attaining age 55 and have a combination of age and years of Continuous Service immediately prior to retirement (10 years minimum, or for employees hired prior to January 1, 2001, 5 years minimum) that total 70 years or more may participate in the Medical Plan with their covered dependents by paying the required retiree premiums. For example: An employee age 55 would be eligible for retiree medical coverage after 15 years of Continuous Service. A 62 year old employee would be eligible after 10 years of Continuous Service, if hired on or after January 1, 2001. A 62 year old employee would be eligible after 8 years of Continuous Service, if hired before January 1, 2001.

Also, employees who are participating in the Medical Plan and who terminate employment after completing 35 years of Continuous Service may participate in the Medical Plan with their covered dependents by paying the required retiree premiums.

In addition, when Long Term Disability (LTD) Plan benefits cease for a participant who was receiving such benefits, the following criteria apply in determining retiree medical benefits eligibility, if participating in the Medical Plan. Use Continuous Service prior to commencement of LTD Plan benefits and age at the time the LTD Plan benefits cease.

Retirees otherwise eligible who are subsequently employed elsewhere or have coverage available through their spouse's employer may suspend their retiree medical coverage through the Laboratory. It may only be reinstated during an Open Enrollment Period (effective January 1 of the following calendar year) or when a Qualifying Event occurs.

Employees Hired Prior to January 1, 1988

All employees hired prior to January 1, 1988 who are participating in the Medical Plan and who terminate employment during the calendar year in which they attain age 55, 56, or 57 and have completed three or more years of Continuous Service may participate in the Medical Plan with their covered dependents by paying the COBRA cost of the plan, provided they do not become eligible for coverage under another group medical insurance plan.

At age 58, the following information applies. Employees who (1) terminate employment during the calendar year in which they attain age 58 or later and have at least three years of Continuous Service or (2) continue medical insurance in accordance with the provisions of the preceding paragraph, may participate in the Medical Plan with their covered dependents by paying the required retiree premiums.

ENROLLMENT

Eligible employees may enroll in one of the medical programs within 30 days of their date of hire. Once you enroll, you must continue participation in the program until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and list all dependents you want covered. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. The coverages available are:

- Employee only.
- Employee and one dependent.
- Employee and two or more dependents.

You cannot enroll your eligible dependents without also enrolling yourself for medical coverage. Employees cannot enroll their dependents in a different medical program than the one they select for themselves.

Coverage begins on your date of hire if you complete all enrollment forms and submit them to the Benefits Office within 30 days of your date of hire.

MEDICAL PROGRAMS AVAILABLE

Eligible employees and their dependents may enroll in one of the non-Medicare medical programs.

Non-Medicare-eligible retirees, non-Medicare-eligible participants receiving LTD Plan benefits, and non-Medicare eligible dependents of retirees and participants receiving LTD Plan benefits may enroll in one of the non-Medicare medical programs.

Medicare-eligible retirees, Medicare-eligible participants receiving LTD Plan benefits, and Medicare-eligible dependents of retirees and participants receiving LTD Plan benefits may enroll in one of the Medicare medical programs.

Employees who were members of the International Brotherhood of Electrical Workers (IBEW) Union and either retire after 7/31/00 or terminate employment after 7/31/00 and are receiving LTD Plan benefits and become Medicare-eligible retirees, Medicare-eligible participants receiving LTD Plan benefits, or Medicare-eligible dependents of retirees and participants receiving LTD Plan benefits may enroll in the Indemnity program, administered by CIGNA, or one of the Medicare HMOs.

A brief summary of the benefits provided under each program is at the end of the Medical Plan section.

Medical Programs Available As Of January 1, 2006	
Non-Medicare-Eligible Participants	**Medicare-Eligible Participants**
Aetna HMO	CIGNA Open Access Plus*
CIGNA Open Access Plus for non-IBEW (CIGNA PPO for IBEW members**)	HIP VIP HMO
HIP HMO	CIGNA Indemnity*
Vytra PPO for non-IBEW (Vytra HMO for IBEW members**)	

* The CIGNA Open Access Plus is not available to IBEW Union members who terminated employment on or after 8/1/00. CIGNA Indemnity is only available to IBEW Union members who terminated employment on or after 8/1/00.

**and former IBEW members who terminated employment on or after 8/1/00.

- If you and your spouse are **not** eligible for Medicare, you may both participate in a non-Medicare plan but must both elect the same plan.
- If you and your spouse are eligible for Medicare, you may both participate in a Medicare plan but must both elect the same plan.
- If you are **not** eligible for Medicare but your spouse is eligible for Medicare (or vice versa), the Medicare-eligible participant may participate in any of the Medicare plans. The non-Medicare-eligible participant may participate in any of the non-Medicare plans.

THE OPEN ACCESS PLUS (OAP) AND THE PREFERRED PROVIDER ORGANIZATION (PPO), ADMINISTERED BY CIGNA

Under the CIGNA OAP and PPO programs, services are provided through a network of physicians and facilities, but benefits are also provided for use of providers who are not in the network.

If services are received from an in-network provider, there is no claim filing. Most in-network services are covered in full after a small co-payment.

If services are received from a provider who is not in the respective CIGNA OAP or PPO network (thus is out-of-network), you have a deductible, must file claim forms, and most services are covered at 80% of the Reasonable and Customary (R&C) amount.

The CIGNA OAP and PPO programs provide benefits to cover in-hospital and out-of-hospital expenses. Under these programs, you use the physician of your choice for medical care for you and your covered dependents. For expenses to be covered by the program, they must be for necessary and essential care and treatment of an injury, illness, or pregnancy. Certain facilities and care providers may not be covered by this program.

Additional information on benefits, exclusions, and limitations is provided in your CIGNA Insurance Certificate which is available at no charge in the Benefits Office.

THE INDEMNITY PROGRAM, ADMINISTERED BY CIGNA

The indemnity program provides basic and major medical benefits for covered expenses. Major medical expenses include many hospital and non-hospital charges not covered by the basic portion of the program. Under this medical program, you use the physician of your choice for medical care for you and your covered dependents and submit a claim form for reimbursement of Reasonable and Customary (R&C) covered medical expenses. It is a fee-for-service program. Major medical expenses are reimbursed at 80% of the R&C amount after a deductible is met. For expenses to be considered for reimbursement, they must be for necessary and essential care and treatment of an injury, illness, or pregnancy. Certain facilities and care providers may not be covered by this program.

Additional information on benefits, exclusions, and limitations is provided in your CIGNA Insurance Certificate which is available at no charge in the Benefits Office.

THE PREFERRED PROVIDER ORGANIZATION (PPO) ADMINISTERED BY VYTRA

Under the Vytra PPO program, services are provided through a network of physicians and facilities, but benefits are also provided for use of providers who are not in the network.

If services are received from an in-network provider, there is no claim filing. Most in-network services are covered in full after a small co-payment.

If services are received from a provider who is not in the Vytra PPO network (thus is out-of-network), you have a deductible, must file claim forms, and most services are covered at 70% of the Reasonable and Customary (R&C) amount.

The Vytra PPO program provides benefits to cover in-hospital and out-of-hospital expenses. Under this program, you use the physician of your choice for medical care for you and your covered dependents. For expenses to be covered by the program, they must be for necessary and essential care and treatment of an injury, illness, or pregnancy. Certain facilities and care providers may not be covered by this program.

Additional information on benefits, exclusions, and limitations is provided in your Vytra Insurance Certificate which is available at no charge in the Benefits Office.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

HMO programs are available for medical coverage. Currently, non-Medicare HMOs are provided through Aetna, HIP, and Vytra and a Medicare HMO is provided through HIP. Information on the benefits provided through

the HMOs is contained in literature available at no charge in the Benefits Office. Under the HMOs, services are provided through a network of participating physicians and facilities. Coverage is not provided for providers who are not in the HMO's network. To change providers in your HMO, you must contact the HMO. If you require the care of a medical specialist, your participating physician must give you a referral to a specialist in that HMO's network. Many of the services are provided for a small co-payment. There are no deductibles or claim forms to file. Please note that coverage under the HMOs is subject to change by the HMO and is based on provisions at the time the service is provided. Many preventive services, such as an annual physical, are provided by the HMOs.

If you have any questions about your HMO, contact the HMO.

Authorization

- If your primary care physician believes you need to see a specialist, he or she will provide you with a referral.
- In case of an emergency, you do not require prior approval or authorization by your primary care physician or insurance company. However, you must notify your primary care physician of your visit to the emergency room as soon as reasonably possible.

Preventive Services

Services such as well child care, routine physicals, and routine gynecological examinations are provided. For a list of such services, refer to your member handbook.

PHONE NUMBERS

AETNA:	(800) 323-9930
CIGNA:	(800) 244-6224
HIP:	(800) 447-8255
VYTRA:	(631) 694-6565

PROVIDER DIRECTORY

Provider directories are available at no charge in the Benefits Office or on the Web at:

AETNA:	www.aetna.com
CIGNA:	www.cigna.com
HIP:	www.hipusa.com
VYTRA:	www.vytra.com

COORDINATION OF BENEFITS

Coverage Under Other Employers' Plans

If you and your covered dependents are eligible to receive benefits under another group medical plan, the benefits from that plan will be coordinated with benefits from the OAP, PPO or indemnity programs, so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid by the plans. Benefit credits have been eliminated as of January 1, 2006.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

Coordination of benefits with the HMOs is based on the terms of those plans. In many cases the HMOs do not provide additional reimbursement when coordinated with another group medical plan.

In the case of dependent children who are covered by more than one group plan, the insurance plan of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Both Spouses Covered by the OAP, PPO or Indemnity Programs, Administered by CIGNA (Dual Coverage)

Prior to January 1, 2006, dual coverage allowed both spouses to participate in the CIGNA OAP, PPO, or Indemnity Programs where they could elect to cover each other and their eligible dependents in such programs provided they paid the required premiums. Dual coverage has been eliminated as of January 1, 2006. Participants with such coverage must change their coverage elections for January 1, 2006. This change does not apply to members of the IBEW union.

Medicare

For retired employees, participants who are receiving LTD Plan benefits and their dependents who are eligible for Medicare, the medical programs will not pay for any medical expenses that are eligible for reimbursement

under Medicare. To obtain maximum medical insurance coverage, retired employees, participants who are receiving LTD Plan benefits and their dependents who are eligible for Medicare must enroll for both Parts A and B of Medicare. If the participant does not enroll for Medicare Parts A and B, the participant is not eligible to enroll in a Medicare HMO and the OAP, PPO and indemnity programs, administered by CIGNA, will reduce benefits as if Medicare coverage is in place.

CLAIMS

How to File a Claim

To file a claim under the indemnity program or the out-of-network portion of the OAP or PPO programs you must complete a claim form that is available in the Benefits Office or on the Web at:

www.bnl.gov/HR/Benefits/Medical.asp

If you are retired, on long term disability or a dependent and covered by Medicare, you should submit your bills to Medicare first. For items not covered in full by Medicare, submit the explanation of benefits from Medicare, copies of the bills, and a completed claim form to CIGNA (for the CIGNA indemnity, OAP or PPO plan) or Vytra (for the PPO plan).

Completed OAP, PPO or indemnity program claim forms and copies of your bills should be submitted to the address on the claim form.

There are no claim forms to file under the HMOs. The providers will bill the HMO for you.

Questions About Claims

If you have a question about your CIGNA OAP, PPO or indemnity program claim, you should contact CIGNA. If you have a question about your Vytra PPO claim, you should contact Vytra. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received. You can contact the CIGNA claims administrator at (800) 244-6224 or the Vytra claims administrator at (631) 694-6565.

How to Appeal a Claim

Under the CIGNA PPO and indemnity programs and the Vytra PPO, your explanation of benefits will identify if a claim is denied and the reason for the denial. You may request a review of the denied claim in writing to the insurance company within 180 days of the receipt of the notice of denial. You should state the reasons why you feel your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the insurance company will render a decision within

30 days of the date your request for review is received.

Under the CIGNA OAP program, you may request a review of the denied claim in writing to the insurance company with 365 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Under the Aetna program, you may request a review of the denied claim by contacting the insurance company at (800) 323-9930. You will then receive a written acknowledgement that you must sign and return to the insurance company. Within 15 days of receipt, the insurance company will request additional information. You should provide any additional information to assist them in reviewing the claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Under the HIP program, you may request a review of the denied claim within 180 days of the receipt of an adverse determination notice by contacting the insurance company at (800) 447-8255, or submit your request in writing to HIP Grievance and Appeal Department, P.O. Box 2844, New York, N.Y. 10016 or submit your request in person to the Customer Service Walk-In Unit, 55 Water Street, New York, N.Y. 10071. You will then receive a written acknowledgement within 5 business days of receipt of your request. The insurance company will request additional information which you should provide to assist them in reviewing the claim. In normal cases the insurance company will render a decision within 30 business days of the date your request for review is received for benefit determination or 60 business days for clinical determination. In special cases, such decision may be delayed to a maximum of 60 business days from their receipt of all necessary information.

Under the Vytra HMO program, you may request a review of the denied claim within 180 days of the receipt of the denied claim by contacting the insurance company at (800) 871-5281, or submit your request in writing to Vytra Health Plans, 395 North Service Road, Melville, NY 11747. Within 15 days of receipt, the insurance company will acknowledge your appeal. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

EXCLUSIONS

The OAP, PPO and indemnity programs, administered by CIGNA, will not provide payment for:

- Expenses that are covered by Workers' Compensation, no-fault automobile insurance, or uninsured motorist insurance law.

- Charges for unnecessary services or charges which you would not be legally required to pay or which would not have been made if there was no insurance.
- Charges for supplies, care, treatment or surgery, which are not considered essential for the care and treatment of an injury or sickness.
- Charges in excess of reasonable and customary limits or program maximums.
- Charges for private duty nursing while confined as an inpatient.
- Charges for or in connection with custodial services, education or training.
- Expenses for or in connection with experimental procedures, treatment methods, drugs or substances not approved by the American Medical Association, the Food and Drug Administration, or the appropriate medical society.
- Charges for or in connection with routine refractions, eye exercises, surgical treatment of a refractive error, or purchase or replacement of contact lenses or eyeglasses.
- Charges for or in connection with speech therapy if (a) used to improve speech skills that have not fully developed, (b) considered custodial or educational, or (c) intended to maintain speech communication.
- Charges made by a provider who is a member of your or your dependent's family.
- Charges covered by Medicare.
- Dental x-rays and examinations, and dental work unless made necessary by accidental injury to sound natural teeth.

Additional exclusions may apply. Refer to your CIGNA Insurance Certificate for additional information.

The Aetna, HIP, and Vytra HMO programs will not provide coverage for:

- Expenses that are covered by Workers' Compensation, no-fault automobile insurance, or uninsured motorist insurance law.
- Charges for or in connection with custodial services, education or training.
- Expenses for or in connection with experimental procedures, treatment methods, drugs or substances not approved by the American Medical Association, the Food and Drug Administration, or the appropriate medical society.

- Charges for cosmetic surgery except when such service is incidental to or follows surgery for trauma, infection or other diseases of the part of the body involved. For a covered child, coverage is provided for reconstructive surgery to treat congenital disease or anomaly which results in a functional defect.
- Hearing aids.
- Certain expenses for infertility services.
- Charges made by a provider who is a member of your or your dependent's family.
- Charges covered by Medicare.
- Dental x-rays and examinations, and dental work unless made necessary by accidental injury to sound natural teeth (Aetna and Vytra).

Additional exclusions may apply. For a list of such exclusions refer to your HMO's member handbook.

The Vytra PPO program will not provide coverage for:

- Cosmetic, plastic or reconstructive surgery, except as specified in your Certificate of Coverage;
- Disabilities connected to military service;
- Examinations required for employment, school, licensing, insurance, etc.;
- Transportation, except in the case of an emergency;
- Dental care, except as specified in your Certificate of Coverage;
- Custodial care, except as may be covered through Hospice Care or by a Skilled Nursing Facility;
- Personal or comfort items, subject to your rights to an appeal, and external review.

Additional exclusions may apply. Contact Vytra for information on such exclusions.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or

newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

WOMEN'S BREAST CANCER

Federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services are subject to deductibles, co-insurance and co-payment amounts that are consistent with those that apply to other benefits under the plan.

EMPLOYEE PREMIUMS

Employees who elect to participate in the Medical Plan must pay the required premiums. For employees who are not members of the IBEW union, your premiums are based on your Base Salary, the cost of the plan you elect, and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. For employees who are members of the IBEW union or the SCSPA union, your premiums are based on your Base Salary, and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. You may pay your premiums with before-tax or after-tax dollars. Before-tax premiums are deducted from your pay before state and federal income taxes and Social Security taxes are withheld, resulting in a lower actual cost to you. After-tax premiums are deducted from your pay after taxes are withheld and result in no tax savings to you. Employee premiums are indicated at the end of the Medical Plan section.

If your annual salary is below the Social Security wage base and you pay your premiums with before-tax dollars, your future Social Security benefits may be reduced.

RETIREE PREMIUMS

Retiree premiums are affected by both your eligibility for Medicare and the Medicare eligibility of your covered dependents. If a participant lives outside of the United States and is ineligible for Medicare, the premium for that participant for Medical Plan coverage will be the Medicare Part B premium in addition to any other required Medical Plan premium.

Retiree premiums are indicated at the end of the Medical Plan section, and are subject to change.

DISPLACED WORKERS HEALTH BENEFITS PROTECTION ACT (DWHBP) PREMIUMS

Employees who are terminated from employment as part of a reduction-in-force may continue their medical coverage by paying the required premiums. Premiums during the first year after termination of employment will be the active employee premium based on your Base Salary on the day immediately preceding termination of employment. During the second year, premiums will be one-half of the applicable COBRA premium. After the second year, such participants may continue coverage under COBRA for up to 18 months. Premiums are indicated at the end of the Medical Plan section. Such DWHBP benefits as described in this section are not available to participants, their spouse or their dependent child if eligible for Medicare, retiree medical coverage, or for coverage under another employer's group health plan. If a participant is ineligible for DWHBP benefits, they may be eligible to continue coverage for up to 18 months under COBRA.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may change medical programs, drop coverage and/or add or drop dependents from your coverage. Employees who did not previously elect medical coverage may elect it during the Open Enrollment Period. Participants receiving LTD Plan benefits, retirees, and their dependents who did not previously elect medical coverage, may not elect it during the Open Enrollment Period. Changes you elect during the Open Enrollment Period will be effective January 1 of the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within 31 days of the event.

QUALIFYING EVENT

A Qualifying Event is a change in your family status and includes:

(a) Change in legal marital status

1. marriage
2. death of spouse
3. divorce
4. legal separation
5. annulment

(b) Change in the number of dependents

1. birth
2. adoption
3. placement for adoption
4. death of a dependent

(c) Change in employment status

1. termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)

(d) Changes in work schedule

1. an increase or decrease in the number of hours of employment by the employee, spouse or dependent
2. a switch between full-time and part-time status
3. a strike or lockout
4. commencement or return from an unpaid leave of absence

(e) The dependent satisfies or ceases to satisfy the requirements for unmarried dependents

1. attainment of age
2. student status

(f) A change in the place of residence or work site of the employee, spouse or dependent

You have 31 days from the date of a Qualifying Event to make changes to your medical coverage for all items indicated above except (a)(3), (a)(4), (e)(1) and (e)(2). You have 60 days from the date of a Qualifying Event to make changes to your medical coverage for items (a)(3), (a)(4), (e)(1) and (e)(2). The change requested must relate to the change in your family status that affects eligibility for medical coverage. Changes are made by completing an enrollment form, available in the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your medical coverage within the applicable period indicated above, you must wait until the next Open Enrollment Period.

MISCELLANEOUS

Base Salary

Base Salary for the purpose of the medical programs means your basic rate of pay, before any salary reductions. It does not include overtime, bonuses, or any other compensation. For part-time employees, Base Salary is based on the full-time equivalent basic rate of pay. For union employees, Base Salary is based on the terms of the union contract.

Continuous Service

Continuous Service means service from your most recent hire date. Service performed prior to a break in employment is not included in Continuous Service. Continuous Service will be reduced by periods on approved Leave of Absence and will not include periods when the employee is not eligible for medical benefits. Continuous Service shall include Continuous Service, if any, with Associated Universities, Inc., Battelle Memorial Institute, Research Foundation of the State University of New York or the State University of New York at Stony Brook immediately prior to a transfer of employment to Brookhaven Science Associates, LLC.

Deductible

Under the OAP and the PPO (out-of-network portion) and indemnity programs, the Deductible is the amount you pay out of your pocket before you receive reimbursement for covered medical expenses. The Deductible does not include expenses that exceed the Reasonable and Customary charges.

For all non-IBEW union participants (and IBEW union participants who terminated employment before August 1, 2000):

- The annual Deductible for the OAP program, administered by CIGNA, is as follows:

	Annual Calendar Year Deductible Individual	Family
— For active employees	$500	$1500
— For retirees and participants who are receiving LTD plan benefits and who are not receiving Medicare benefits	$500	$1500
— For retirees who are receiving Medicare benefits	$500	$1500
— For participants who are receiving LTD Plan benefits and are receiving Medicare benefits	$500	$1500

- The annual Deductible for the Vytra PPO program is $2,000 per individual ($4,000 per family) per calendar year.

For all active employees who are members of the IBEW union, IBEW union members who terminated employment on or after August 1, 2000, and active employees who are members of the SCSPA union:

- The annual Deductible for the indemnity program, administered by CIGNA, is $250 per individual ($650 per family) per calendar year.
- The annual Deductible for the PPO program, administered by CIGNA, is as follows:

	Annual Calendar Year Deductible	
	Individual	**Family**
— For active employees	$250	$650
— For retirees and participants who are receiving LTD Plan benefits and who are not receiving Medicare benefits	$250	$650

In general:

- In-network CIGNA OAP and PPO and Vytra PPO medical expenses do not have a Deductible nor do they count toward the Deductible.
- If three or more members of a family incur total out-of-pocket expenses, during the calendar year, in excess of the Family Deductible, no further Deductible amounts are required for the entire family during the remainder of that year.
- The deductibles indicated above do not apply to the HMOs.
- In addition to the above, there is a separate $100 per individual ($300 per family) annual prescription deductible for the OAP and PPO programs, administered by CIGNA, and the Vytra PPO and HMO programs. This applies, in total, to both the retail pharmacy and mail order portions of the program. This does not apply to active employees who are members of the IBEW union, IBEW union

members who terminated employment on or after August 1, 2000, and active employees who are members of the SCSPA union.

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination of the plan, and privacy of information can be found in the General Information section of this booklet.

Hospital Preadmission Certification

Under the OAP, PPO and indemnity programs, administered by CIGNA, all covered participants must obtain Hospital Preadmission Certification. This certification is mandatory for a hospital stay of one or more nights. If you are retired or disabled and covered by Medicare, you are not required to pre-certify your hospital admission.

If Hospital Preadmission Certification is not obtained, a $250 penalty will be applied to the OAP and PPO programs, administered by CIGNA. A $250 penalty applies to the Vytra PPO program. In addition, under the OAP and PPO programs, administered by CIGNA, benefits for any days not approved by the insurance company will be reduced by 50% of the amount otherwise payable. The expenses that you incur because of these benefit limitations will not apply to your Out-Of-Pocket Maximum.

For Hospital Preadmission Certification, call the toll free phone number provided on your medical identification card before admission to the hospital or within 48 hours of an emergency admission.

Under the HMOs, you must call the telephone number shown on your medical identification card to obtain approval for hospital care or the applicable claims will be denied.

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, you may continue your medical coverage during the term of the approved leave from the starting date of your leave by paying the required employee premiums. This coverage will cease when the employee is no longer on the approved Leave of Absence. Participants on approved military leave may drop medical coverage for themselves while continuing to cover their dependents.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer

is an agency or prime contractor of the federal government that will cover you under its insurance program.

If you drop medical coverage while on an approved Leave of Absence, you may enroll again upon your return to work in an eligible status.

Lifetime Maximum Medical Benefits

There is no lifetime maximum amount of medical benefits under the OAP and PPO programs, administered by CIGNA, the Vytra PPO and the HMOs.

Under the indemnity program, administered by CIGNA, the lifetime maximum amount of major medical benefits for which the program will provide reimbursement is $1,000,000 per covered participant.

Out-Of-Pocket Maximum

Under the OAP and PPO (out-of-network portion) and indemnity programs, administered by CIGNA and the Vytra PPO (out-of-network portion), when a participant incurs the amount of covered out-of-pocket medical expenses indicated below, in addition to the Individual Deductible, medical expenses for that person will be reimbursed at 100% of the R&C amount for the remainder of the calendar year. This does not apply to outpatient expenses for the care of mental illness, functional nervous disorders or substance abuse for dependents. In-network OAP and PPO expenses do not count toward the out-of-pocket maximum.

	Annual Calendar Year Out-Of-Pocket Maximum	
	Individual	**Family**
■ OAP Program (for participants who are not active members of the IBEW union or members of the IBEW union who terminated employment on or after 8/1/00)	$2500	$7500
■ OAP Program (for participants who are active members of the SCSPA union)	$1200	$2400
■ CIGNA PPO Program (for participants who are active members of the IBEW union, or members of the IBEW union who terminated employment on or after 8/1/00)	$1200	$2400
■ Indemnity Program	$900 per covered participant	
■ Vytra PPO (for participants who are not active members of the IBEW union or members of the IBEW union who terminated employment on or after 8/1/00)	$5000	$10000
■ Aetna HMO	$1500	$3000

■ An annual out-of-pocket maximum does not apply to the HIP and Vytra HMOs.

Participants Receiving Long Term Disability Plan Benefits

Participants who are receiving LTD Plan benefits may continue medical coverage for themselves and their eligible dependent(s). Currently, no premium is required to continue this coverage while receiving LTD Plan benefits. This coverage will cease when the employee is no longer eligible to receive LTD Plan benefits. If the participant is then eligible for retiree medical benefits, the participant may continue medical coverage by paying the required retiree premiums.

Qualified Medical Child Support Order

Information on the administration of a qualified medical child support order can be obtained at no charge from the Benefits Office.

Reasonable and Customary (R&C)

Under the OAP, PPO and indemnity programs, a charge is considered Reasonable and Customary if it is the normal charge made by the provider for a similar service or supply and it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by the insurance company.

Second Surgical Opinion

Under the OAP, PPO and indemnity programs, administered by CIGNA, if you or your dependents would like a second surgical opinion, you may call the telephone number provided on your medical identification card. They will assist you.

Under the CIGNA OAP or PPO program, if you use a provider who is not in CIGNA's network, the program will pay the full Reasonable and Customary cost of a second surgical opinion after one surgeon has recommended surgery—including any necessary diagnostic exams and laboratory fees. In addition, the program will pay 100% of the Reasonable and Customary cost of a third opinion if the first two opinions conflict. You do not have to satisfy the Deductible in order to receive 100% reimbursement under this section. Under the PPO program, if you use a provider who is in CIGNA's network, you are required to pay a small co-payment for diagnostic exams and laboratory fees.

Under the Vytra PPO program, you should discuss your request with your participating provider, who will contact Vytra for precertification. If you use a provider who is not in Vytra's PPO network, out-of-network benefits will apply.

Under the HMOs, second surgical opinions are based on the terms of

the program. You must call the telephone number shown on your medical identification card to obtain the procedures for a second surgical opinion.

Termination of Coverage

Medical coverage for active employees, and their dependents under the Medical Plan will cease on the earlier of the date your employment terminates, the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Medical coverage for retirees and their dependents and participants receiving LTD Plan benefits will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse also ceases due to divorce or legal separation from you. Coverage for your dependent children also ceases when the child no longer meets the eligibility requirements of this plan, such as due to graduation or attainment of age 19 and no longer attending an accredited college or university on a full-time basis.

COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is

lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Office has been notified that a qualifying event has

occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of the notice from the Benefits Office, your group medical insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the same medical coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare

entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefits Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Medical Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The group health care plan is terminated for active employees.

CONVERSION

You or your dependents may be entitled to convert your medical coverage to an individual policy if (a) you were insured under the PPO, OAP or indemnity programs, administered by CIGNA, for the three months immediately prior to when coverage ceased, (b) coverage ceased because you were no longer in active employment or no longer eligible for Medicare, or (c) coverage ceased due to ineligibility. You are not eligible for a converted policy if insurance under this plan is replaced by similar coverage within 45 days. If you qualify for conversion, no medical examination will be required, but you must apply in writing and pay the premium for the coverage to the insurance company within 45 days from the date your group medical insurance coverage ceased. The necessary application forms are available directly from the insurance companies.

ERISA

Refer to the General Information section of this booklet for information regarding your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

EMPLOYEE PREMIUMS

FOR EMPLOYEES WHO ARE NOT IN THE IBEW UNION OR THE SCSPA UNION (January 1, 2006)

Monthly Contribution

For monthly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
$0 - $39,999.99	Aetna HMO	$ 42.44	$ 79.31	$120.09
	CIGNA OAP	$ 47.98	$100.96	$138.50
	HIP HMO	$ 31.42	$ 57.36	$91.33
	Vytra PPO	$ 37.69	$ 75.42	$108.77
$40,000 - $69,999.99	Aetna HMO	$ 63.66	$118.97	$180.14
	CIGNA OAP	$ 71.96	$151.43	$207.75
	HIP HMO	$ 47.12	$ 86.05	$136.99
	Vytra PPO	$ 56.54	$113.13	$163.16
$70,000 - $99,999.99	Aetna HMO	$ 80.64	$150.69	$228.17
	CIGNA OAP	$ 91.15	$191.82	$263.15
	HIP HMO	$ 59.69	$108.99	$173.53
	Vytra PPO	$ 71.62	$143.29	$206.67
$100,000 and over	Aetna HMO	$101.86	$190.34	$288.22
	CIGNA OAP	$115.14	$242.29	$332.40
	HIP HMO	$ 75.40	$137.67	$219.19
	Vytra PPO	$ 90.46	$181.00	$261.06

Weekly Contribution

For weekly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
$0 - $39,999.99	Aetna HMO	$ 9.79	$18.30	$27.71
	CIGNA OAP	$11.07	$23.30	$31.96
	HIP HMO	$ 7.25	$13.24	$21.08
	Vytra PPO	$ 8.70	$17.40	$25.10
$40,000 - $69,999.99	Aetna HMO	$14.69	$27.45	$41.57
	CIGNA OAP	$16.61	$34.95	$47.94
	HIP HMO	$10.87	$19.86	$31.61
	Vytra PPO	$13.05	$26.11	$37.65
$70,000 - $99,999.99	Aetna HMO	$18.61	$34.77	$52.65
	CIGNA OAP	$21.04	$44.27	$60.73
	HIP HMO	$13.77	$25.15	$40.04
	Vytra PPO	$16.53	$33.07	$47.69
$100,000 and over	Aetna HMO	$23.51	$43.93	$66.51
	CIGNA OAP	$26.57	$55.91	$76.71
	HIP HMO	$17.40	$31.77	$50.58
	Vytra PPO	$20.88	$41.77	$60.24

For medical plan participants who are receiving BSA Long Term Disability Plan benefits:
January 1, 2006 Premium: $0.00

*The Base Salary category for eligible part-time employees is based on their full-time equivalent salary.

These premiums are subject to change.

EMPLOYEE PREMIUMS

FOR IBEW UNION EMPLOYEES
(January 1, 2006)

Weekly Premium

For weekly paid employees:

Medical Plan	Coverage		
	Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
All Plans	3% of Base Salary*	3.5% of Base Salary*	4% of Base Salary*

For medical plan participants who are receiving BSA Long Term Disability Plan benefits:
January 1, 2006 Premium: $0.00

FOR SCSPA UNION EMPLOYEES
(January 1, 2006)

Weekly Premium

For weekly paid employees:

Annual Base Salary*	Medical Plan	Coverage		
		Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
Less than $30,000	All Plans	$ 5.22	$ 7.98	$ 10.73
$30,000 - $39,999.99	All Plans	$ 7.43	$ 11.00	$ 14.85
$40,000 - $59,999.99	All Plans	$ 9.63	$ 14.30	$ 19.25
$60,000 - $79,999.99	All Plans	$ 12.67	$ 19.03	$ 25.37
$80,000 and over	All Plans	$ 16.48	$ 24.74	$ 32.98

For medical plan participants who are receiving BSA Long Term Disability Plan benefits:
January 1, 2006 Premium: $0.00

*The Base Salary category for eligible part-time employees is based on their full-time equivalent salary.

These premiums are subject to change.

RETIREE PREMIUMS

FOR PARTICIPANTS WHO WERE NOT IN THE IBEW UNION
(January 1, 2006)

Monthly Premium

Retirement Date	Medicare-Eligible	Medical Plan(s)	Annual Base Salary*	Coverage		
				One Person	2 People	3 or More People
Prior to 10/1/95	N/A	Aetna HMO CIGNA OAP HIP HMO HIP VIP HMO Vytra PPO	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/95 - 9/30/96	No	Aetna HMO	Less than $30,000	$10.29	$ 15.71	$ 21.13
		CIGNA OAP	$30,000 - $39,999.99	$14.63	$ 21.67	$ 29.25
		HIP HMO	$40,000 - $59,999.99	$18.96	$ 28.17	$ 37.92
		Vytra PPO	$60,000 and over	$24.97	$ 37.48	$ 49.97
10/1/95 – 12/31/01	Yes	CIGNA OAP HIP VIP HMO	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/96 – 12/31/01	No	Aetna HMO	Less than $30,000	$20.58	$ 31.42	$ 42.25
		CIGNA OAP	$30,000 - $39,999.99	$29.25	$ 43.33	$ 58.50
		HIP HMO	$40,000 - $59,999.99	$37.92	$ 56.33	$ 75.83
		Vytra PPO	$60,000 and over	$49.93	$ 74.95	$ 99.94
1/1/02 or later	Yes	CIGNA OAP	N/A	$53.53	$107.06	
		HIP VIP (Suffolk)	N/A	$57.31	$114.62	
1/1/02 or later	No	Aetna HMO	N/A	$84.88	$158.62	$240.18
		CIGNA OAP	N/A	$95.95	$201.91	$277.00
		HIP HMO	N/A	$62.83	$114.73	$182.66
		Vytra PPO	N/A	$75.39	$150.83	$217.55

**The Base Salary category is based on your full-time equivalent salary on the day immediately preceding your retirement. If you retired from long term disability status, the Base Salary category is based on your full-time equivalent salary on the day immediately preceding your termination of employment.*

These premiums are subject to change.

RETIREE PREMIUMS

FOR PARTICIPANTS WHO WERE IN THE IBEW UNION (January 1, 2006)

Monthly Premium

Retirement Date	Medicare-Eligible	Medical Plan(s)	Annual Base Salary*	Coverage		
				One Person	2 People	3 or More People
Prior to 10/1/95	N/A	Aetna HMO CIGNA OAP HIP HMO HIP VIP HMO Vytra PPO	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/95 - 9/30/96	No	Aetna HMO CIGNA OAP HIP HMO Vytra PPO	Less than $30,000	$10.29	$15.71	$ 21.13
			$30,000 - $39,999.99	$14.63	$21.67	$ 29.25
			$40,000 - $59,999.99	$18.96	$28.17	$ 37.92
			$60,000 and over	$24.97	$37.48	$ 49.97
10/1/95 – 7/31/00	Yes	CIGNA OAP HIP VIP	N/A	$ 0.00	$ 0.00	$ 0.00
10/1/96 – 7/31/00	No	Aetna HMO CIGNA OAP HIP HMO Vytra PPO	Less than $30,000	$20.58	$31.42	$ 42.25
			$30,000 - $39,999.99	$29.25	$43.33	$ 58.50
			$40,000 - $59,999.99	$37.92	$56.33	$ 75.83
			$60,000 and over	$49.93	$74.95	$ 99.94
8/1/00 – 12/31/03	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Less than $30,000	$22.64	$34.56	$ 46.48
			$30,000 - $39,999.99	$32.18	$47.66	$ 64.35
			$40,000 - $59,999.99	$41.71	$61.96	$ 83.41
			$60,000 and over	$54.92	$82.45	$109.93
8/1/00 or later	Yes	CIGNA Indemnity HIP VIP	N/A	$ 0.00	$ 0.00	$ 0.00
1/1/04 or later	No	Aetna HMO CIGNA PPO HIP HMO Vytra HMO	Actual Monthly Base Salary*	3% of Monthly Base Salary*	3.5% of Monthly Base Salary*	4% of Monthly Base Salary*

**The Base Salary category is based on your full-time equivalent salary on the day immediately preceding your retirement. If you retired from long term disability status, the Base Salary category is based on your full-time equivalent salary on the day immediately preceding your termination of employment. If you terminated employment prior to 8/1/00 and retired immediately after you were no longer eligible for LTD Plan benefits, your premiums are based on the cost of the plan. If you terminated employment on or after 8/1/00 and retired immediately after you were no longer eligible for LTD Plan benefits, your premiums are based on the employee premiums.*

These premiums are subject to change.

DWHBP PREMIUMS

- During 1st year following termination of employment: see Employee Premiums.
- During 2nd year following termination of employment: one-half of COBRA Premiums.

These premiums are subject to change.

COBRA PREMIUMS

FOR PARTICIPANTS WHO WERE NOT IN THE IBEW UNION OR THE SCSPA UNION (January 1, 2006)

Monthly Premium

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna HMO	$432.89	$ 808.96	$1224.92
CIGNA OAP	$489.36	$1029.75	$1412.68
CIGNA OAP for Medicare Eligible Participants	$272.99	$ 545.99	
HIP HMO	$320.44	$ 585.11	$ 931.56
HIP VIP HMO (Suffolk) for Medicare Eligible Participants	$292.26	$ 584.52	
Vytra PPO	$384.47	$ 769.25	$1109.49

FOR PARTICIPANTS WHO WERE IN THE IBEW UNION (January 1, 2006)

Monthly Premium

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna HMO	$473.38	$ 884.44	$1339.16
CIGNA PPO	$513.81	$1081.23	$1483.30
HIP HMO	$380.50	$ 694.74	$1106.11
HIP VIP HMO (Suffolk) for Medicare Eligible Participants	$292.26	$ 584.52	
Vytra HMO	$448.76	$ 897.81	$1294.83
CIGNA Indemnity for Medicare Eligible Participants	$266.32	$ 539.31	

FOR PARTICIPANTS WHO WERE IN THE SCSPA UNION (January 1, 2006)

Monthly Premium

Medical Plan	Coverage		
	One Person	2 People	3 or More People
Aetna HMO	$453.70	$ 848.03	$1284.08
CIGNA OAP	$489.36	$1029.75	$1412.68
CIGNA OAP for Medicare Eligible Participants	$272.99	$ 545.99	
HIP HMO	$375.30	$ 685.30	$1091.04
HIP VIP HMO (Suffolk) for Medicare Eligible Participants	$292.26	$ 584.52	
Vytra PPO	$393.90	$ 788.07	$1136.62

These premiums are subject to change.

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES, NON-MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES (EMPLOYEES *NOT* IN IBEW UNION)

	CIGNA Open Access Plus			Vytra PPO		
	In-Network	Out-of-Network	Aetna (HMO)	In-Network	Out-of-Network	HIP (HMO)
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms
Age Limit for Dependent Children/ Full-Time Student	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/ End of the year age 23	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/ End of the year age 23
Annual Deductible (Individual/Family)	N/A	$500/$1500**	N/A	N/A	$2000/$4000	N/A
Annual Out-of-Pocket Maximum (Individual/Family) (Excluding Deductible)	N/A	$2500/$7500***	$1500/$3000	N/A	$5000/$10000	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A	N/A
Office Visits**	Covered in full after $20 co-pay PCP $30 co-pay Specialist	80% of R&C after deductible	Covered in full after $20 co-pay PCP $25 co-pay Specialist	Covered in full after $20 co-pay PCP $30 co-pay Specialist	70% of R&C after deductible	Covered in full after $20 co-pay PCP $30 co-pay Specialist
Emergency Room (Accident)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after $50 co-pay (waived if admitted)	Emergency: Covered in full after $50 co-pay. (waived if admitted) Non-emergency: only covered out-of-network: 70% of R&C after deductible		Covered in full after $50 co-pay (waived if admitted)
(Illness)	Covered in full					
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	Covered in full Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.	70% of R&C	Covered in full after deductible
(Physician)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
(Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full after $25 co-pay	Covered in full after $30 co-pay	100% of R&C	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full	70% of R&C after deductible	Covered in full after $20 co-pay
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $20 co-pay	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $20 co-pay
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
Prescription Medication (Retail)	*$10 generic/ $25 brand formulary/ $40 brand non-formulary (up to 30-day supply)	Must use in-network pharmacy	$10 generic/ $20 brand formulary/ $40 brand non-formulary (up to 30-day supply)	*$10 generic/ $25 brand formulary/ $40 brand non-formulary (up to 30-day supply)	In-network only	$15 generic/ $30 brand formulary/ $50 brand non-formulary (up to 30-day supply)
(Mail Order)	*$20 generic/ $50 brand formulary/ $80 brand non-formulary (up to 90-day supply)	Must use in-network benefit	$20 generic/ $40 brand formulary/ $80 brand non-formulary (31 to 90-day supply)	*$20 generic/ $50 brand formulary/ $80 brand non-formulary (up to 90-day supply)	In-network only	$22.50 generic/ $45 brand formulary $150 brand non-formulary (up to 90-day supply)

*After meeting a $100 per person/$300 per family annual drug deductible (the drug deductible does not apply to active employees in the SCSPA union, and SCSPA drug co-pays are as follows: CIGNA: $5/$15/$30; Aetna: $5/$10/$25; Vytra: $5/$12/$35; HIP: $5/$10/$35). **$250/$650 for active employees in the SCSPA union. ***$1200/$2400 for active employees in the SCSPA union. **** SCSPA co-pays are $15 PCP/$15 Specialist (R&C = Reasonable & Customary) This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. **1-1-2006**

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES, NON-MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES (EMPLOYEES *NOT* IN IBEW UNION)

	CIGNA Open Access Plus			Vytra PPO		
	In-Network	Out-of-Network	Aetna (HMO)	In-Network	Out-of-Network	HIP (HMO)
Preventive Care (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 17)	70% of R&C after deductible	Covered in full (to age 19)
(Well Woman Exam)****	Covered in full after $20 co-pay	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $20 co-pay
	Covered in full	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full with office visit	70% of R&C after deductible	Covered in full after $20 co-pay
(Mammogram)****	Covered in full	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full	70% of R&C after deductible	Covered in full after $20 co-pay
(Physical Exam)****	Covered in full after $20 co-pay if by PCP	Not covered	Covered in full after $25 co-pay	Covered in full after $20 co-pay if by PCP	Not Covered	Covered in full after $20 co-pay if by PCP
(Routine Eye Exam)****	Not covered	Not covered	Covered in full after $25 co-pay	Covered in full after $30 co-pay (1 exam/year)	Not Covered	Covered in full (for optometrist)
Mental Health Care (Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Covered in full (Max: 30 days/year combined in/out)	70% of R&C after deductible	Covered in full (Max: 30 days/year)
(Outpatient)****	Covered in full after $30 co-pay/ visit	80% of R&C after deductible	Covered in full after $25 co-pay/visit (Max: 20 visits/year)	Covered in full after $30 co-pay (Max: 20 visits/year combined in/out)	70% of R&C after deductible	Covered in full after $25 co-pay/visit (Max: 20 visits/year)
Substance Abuse Treatment (Inpatient Detoxification)	Covered in full	Same as inpatient hospital	Covered in full	Covered in full (Max: 3 periods/year combined in/ out)	70% of R&C after deductible	Covered in full (Max: 7 days/year)
(Outpatient Rehabilitation)****	Covered in full after $30 co-pay/visit	80% of R&C after deductible	Covered in full after $25 co-pay/visit Max: 60 visits/year)	Covered in full after $30 co-pay/visit (Max: 60 visits/year combined in/out)	70% of R&C after deductible	Covered in full after $25 co-pay/visit (Max: 60 visits/year)
Alternate Care (Home Health Care)	Covered in full (Max: 40 visits/year combined in-and out-of-network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 40/ visits/year combined in/out)	70% of R&C after deductible	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility)	Covered in full (Max: 60 days/year combined in-and out-of-network)	80% of R&C after deductible	Covered in full	Covered in full (Max: 45 days/year combined in/out)	70% of R&C after deductible	Covered in full
(Outpatient Short-Term Rehabilitation: Physical Therapy)****	Covered in full after $30 co-pay	80% of R&C after deductible	Covered in full after $25 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after $30 co-pay (Max: 60 consecutive days/injury/lifetime combined in/out)	70% of R&C after deductible	Covered in full after after $30 co-pay (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	70% of R&C after deductible	Covered in full
Hearing Aids	Covered in full ————(Max: $2000/1095 days)————	80% of R&C after deductible	Not covered	Not covered	Not covered	Not covered

**** SCSPA co-pays are $15 PCP/$15 Specialist. This is a brief summary and thus is not an all-inclusive description of services.
Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary)

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES IN IBEW UNION

	CIGNA Preferred Provider Option (PPO)		Aetna (HMO)	Vytra (HMO)	HIP (HMO)
	In-Network	Out-of-Network			
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	No claim forms
Age Limit for Dependent Children/ Full-Time Student	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/ End of the year age 23	To age 19/ End of the year age 23	End of the month age 19/ End of the year age 23
Annual Deductible (Individual/Family)	N/A	$250/$650	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual/Family) (Excluding Deductible)	N/A	$1200/$2400	$1500/$3000	N/A	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A
Office Visits	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
Emergency Room (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after $35 co-pay (waived if admitted)	Covered in full after $25 co-pay (waived if admitted)	Covered in full after $50 co-pay (waived if admitted)
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	Covered in full	Covered in full
(Physician)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
(Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	Covered in full
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	Covered in full
Prescription Medication (Retail)	$5 generic/$10 brand (up to 30-day supply)	80% of R&C after deductible	$5 generic/$10 brand formulary/ $25 brand non-formulary (up to 30-day supply)	$5/prescription (up to 31-day supply)	$5 generic/$10 brand (up to 30-day supply)
(Mail Order)	$10 generic/ $20 brand (up to 90-day supply)	Use in-network benefit	$10 generic/$20 brand formulary/ $50 brand non-formulary (31 to 90-day supply)	$10 (up to 90-day supply)	Half of above co-pay (up to 90-day supply)

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary) **1-1-2006**

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR EMPLOYEES IN IBEW UNION

	CIGNA Preferred Provider Option (PPO)		Aetna (HMO)	Vytra (HMO)	HIP (HMO)
	In-Network	Out-of-Network			
Preventive Care (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 17)	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after $10 co-pay	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full with office visit co-pay	Covered in full
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after $5 co-pay	Covered in full	Covered in full
(Physical Exam)	Covered in full after $10 co-pay	Not covered	Covered in full after $5 co-pay	Covered in full after $5 co-pay	Covered in full
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $5 co-pay	Covered in full after $5 co-pay (1 exam/year)	Covered in full (for optometrist)
Mental Health Care (Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Covered in full (Max: 30 days/year)	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$25 co-pay/visit (Max: 20 visits/year)	$5 co-pay visits 1-3 $25 co-pay visits 4-20 (Max: 20 visits/year)	$25 co-pay (Max: 20 visits/year)
Substance Abuse Treatment (Inpatient Detoxification)	Covered in full	Same as inpatient hospital	Covered in full	Covered in full (Max: 3 periods/year)	Covered in full (Max: 7 days/year)
(Outpatient Rehabilitation)	Covered in full after $10 co-pay/ visit	80% of R&C after deductible	$5 co-pay/visit (Max: 60 visits/year)	$5 co-pay/visit (Max: 60 visits/year)	Covered in full (Max: 60 visits/year)
Alternate Care (Home Health Care)	Covered in full	80% of R&C after deductible (Max: 40 visits/year combined in-and out-of-network)	Covered in full	Covered in full (Max: 40 visits/year)	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility)	Covered in full	80% of R&C after deductible (Max: 60 days/year combined in-and out-of-network)	Covered in full	Covered in full (Max: 45 days/year)	Covered in full
(Outpatient Short-Term Rehabilitation: Physical Therapy)	Covered in full after $10 co-pay	80% of R&C after deductible	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	$5 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Not covered	Covered in full	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	Covered in full
Hearing Aids	Covered in full	80% of R&C after deductible ————(Max: $1000/hearing aid/ear/3 yrs)————	Not covered	Not covered	Not covered

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary) **1-1-2006**

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES

	CIGNA Open Access Plus***		HIP VIP (HMO)*****	CIGNA Indemnity***
	In-Network	Out-of-Network		
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Any physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	Submit claim forms
Annual Deductible (Individual /Family)	N/A	$500/$1500	N/A	$250/$650
Annual Out-of-Pocket Maximum (Individual /Family)	N/A	$2500/$7500 excluding deductible	N/A	$900 per person excluding deductible
Lifetime Benefit Max	Unlimited	Unlimited	Unlimited	$1,000,000
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A
Office Visits (Illness/Injury)	Covered in full after $20 co-pay PCP** ($30 co-pay for Specialist)	80% of R&C after deductible	Covered in full for PCP** ($10 co-pay for Specialist)	Illness: 80% of R&C after deductible. Injury: 100% of 1st $100 of R&C if within 48 hours, then 80% of R&C after deductible
Emergency Room (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after $50 co-pay (Doctors/Specialists: $10 co-pay)	Accident: 100% of R&C if within 48 hours. Illness: 80% of R&C after deductible
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.	Covered in full	Covered in full	100% of R&C for 365 days. Then, 80% of R&C after deductible. Pre-admission certification required or penalty of the first $250 & 50% of the remaining charges is applied.
(Physician/Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Physician $15/day (1MD limit) 31-day maximum. Then, 80% of R&C after deductible. Surgeon: based on schedule ($7,200 maximum). Then, 80% of R&C after deductible.
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full	100% of R&C
Laboratory/X-Ray	Covered in full	80% of R&C after deductible	Covered in full	100% of R&C up to applicable limits. Then, 80% of R&C after deductible.
Prescription Medication (Retail: up to 30-day supply)	$10 generic/$25 brand name formulary/ $40 brand name non-formulary****	Must use in-network pharmacy	$5 formulary/ $45 non-formulary	Participating pharmacies: $5 generic/$10 brand name
(Mail Order: 90-day supply)	$20 generic/$50 brand name formulary/ $80 brand name non-formulary****	Use in-network benefit	$7.50 formulary/ $135 non-formulary	$10 generic/$20 brand name

**Primary Care Physician. ***The CIGNA Open Access Plus is not available to participants who were members of the IBEW union who terminated employment on or after 8/1/00. CIGNA Indemnity is only available to IBEW union members who terminated employment on or after 8/1/00. ****After $100 per person/$300 per family annual drug deductible *****Subject to change; pending CMS approval.

This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary)

BROOKHAVEN SCIENCE ASSOCIATES MEDICAL PLAN COMPARISON FOR MEDICARE-ELIGIBLE RETIREES, PARTICIPANTS ON LTD, AND SPOUSES

	CIGNA Open Access Plus***		HIP VIP (HMO)*****	CIGNA Indemnity***
	In-Network	Out-of-Network		
Preventive Care (Well Woman Exam)	Covered in full after $20 co-pay	80% of R&C after deductible	Covered in full	100% of R&C
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full	100% of R&C
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full	100% of R&C
(Annual Physical Exam)	Covered in full after $20 co-pay	Not covered	Covered in full	Not covered
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $10 co-pay (optometrist:1/year)	80% of R&C after deductible if performed by MD
Mental Health Care (Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (190 day lifetime maximum)*	Same as inpatient hospital
(Outpatient)	Covered in full after $30 co-pay	80% of R&C after deductible	$20 co-pay/visit*	80% of R&C after deductible
Substance Abuse Treatment (Inpatient Detoxification)	Covered in full	Same as inpatient hospital	Covered in full (190 day lifetime max)*	Same as inpatient hospital
(Outpatient Rehabilitation)	Covered in full after $30 co-pay/visit	80% of R&C after deductible	$20 co-pay/visit*	80% of R&C after deductible
Alternate Care (Home Health Care)	Covered in full	80% of R&C after deductible	Covered in full (Max: 200 visits/year)	80% of R&C after deductible (Max: 40 visits/year)
	————(Max: 40 visits/year combined in-and out-of-network)————			
(Skilled Nursing Facility) Non-Custodial	Covered in full	80% of R&C after deductible	Covered in full (Max: 100 days per benefit period)	80% of R&C after deductible (Max: 60 days/year)
	————(Max: 60 days/year combined in-and out-of-network)————			
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after $30 co-pay	80% of R&C after deductible	Covered in full after $10 co-pay (Max: 90 visits/year)	80% of R&C after deductible
Hearing Aids	Covered in full	80% of R&C after deductible	Not covered	80% of R&C after deductible (Max: $2000/1095 days)
	————————(Max: $2000/1095 days)————————			
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Covered in full	80% of R&C after deductible
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full	80% of R&C after deductible

* Based on medical necessity up to Medicare limit. **Primary Care Physician. ***The CIGNA Open Access Plus is not available to participants who were members of the IBEW union who terminated employment on or after 8/1/00. CIGNA Indemnity is only available to IBEW union members who terminated employment on or after 8/1/00. *****Subject to change; pending CMS approval.
This is a brief summary and thus is not an all-inclusive description of services. Only covered expenses are provided/reimbursed through the programs. (R&C = Reasonable & Customary)